Transformation Measurement Team
Measures by Goal
January 2016

Healthier People. Health Care Value.

This document is intended to identify the measures that were selected by the Wisconsin State Health Innovation Plan (SHIP) Transformation Measurement team to monitor progress towards the implementation of the goals. Each goal and supporting processes are titled in a table, and identified measures with descriptions, sources, reporting and implementation considerations are included where available. This list of measures and supporting information is not intended to be an exhaustive list of all measures of the goals; rather, it identifies key measures selected by the Transformation Measurement team.

Shared Transformation Measures by Goal					
Goal: Interrupt disease progression across the health and health care continuum as measured by a XX decrease in:					
Measure	**Measure Description**	**Measure Sources**	**Measure Reporting**	**Measuring**	**Considerations/ Limitations**
Diabetes, Hypertension and Depression prevalence rates	Prevalence is generally determined by:[1] 1. Randomly selecting a sample (smaller group) from the entire population, with the goal being for the sample to be representative of the population. (such as: civilian, noninstitutionalized, household population) 2. For a simple representative sample, prevalence is the number of people in the sample with the characteristic of interest, divided by the total number of people in the sample. 3. When samples (instead of	Wisconsin: WHIO, WHA (others?) National Comparisons: CDC	Prevalence is usually expressed as a percentage (5%, or 5 people out of 100), or as the number of cases per 10,000 or 100,000 people, depending on how common the illness or risk factor is in the population.	Several ways to measure and report prevalence exist, which vary according to the timeframe for the estimate: 1. *Point prevalence* is the proportion of a population that has the characteristic at a specific point in time. 2. *Period prevalence* is the proportion of a population that has the characteristic at any point during a given time period of interest. "Past 12 months" is a	1. Methodological differences that may affect comparisons between studies include, but are not limited to: the populations covered; the timing of data collection; sample design; mode of data collection; instruments and surveys used; operational definitions; and, estimation methods. 2. Some individuals may be unaware they have the

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[1] National Institute of Mental Health, http://www.nimh.nih.gov/health/statistics/prevalence/index.shtml

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	entire populations) are used to generate estimates of prevalence, statistical 'weights' may be applied to adjust the sample characteristics to match up with the target population that they were selected to represent.			commonly used timeframe. 3. *Lifetime prevalence* is the proportion of a population who, at some point in life up to the time of assessment, has ever had the characteristic.	condition because it has not been diagnosed. Therefore, prevalence rates may be underestimated. 3. It is impossible to determine if an increase of new cases is because of a true increase in disease incidence, improved case ascertainment, or a combination of these factors. 4. Depending on the source, the definition of the condition may vary. For example, different CPT codes for the condition may be deployed across different sources.
Diabetes, Hypertension and Depression incidence rates	Incidence is the number of newly diagnosed cases of a disease. An incidence rate is the number of new cases of a disease divided by the number of persons at risk for the	Wisconsin: WHIO, WHA (others?) National Comparisons: CDC	1) Incidence rates (density) can be measured in a closed cohort or in an open	Incidence rate = Incidence density = (number of disease onsets) divided by (sum of person - time @ risk)	Generally same as above.

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	disease.		population. Its numerator is the same as incidence proportion, but its denominator is different.	Methods of calculating the "person-time" denominator. 2) In a closed cohort a) Count person-time for each individual in the cohort and sum. b) Break cohort into those who remain healthy (Group 1) and those who develop disease (Group 2). c) (Average population size) × (duration of follow-up) In an open population (e.g., using vital statistics systems): The person-time is approximately equal to (N)(t), where N is average population size and t is the duration of study. For example, a population with an average size of 1000 studied for 1 year accounts for 1000 person-years. In contrast, a population with an average size of 1000 studied for 2	

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				years accounts for $(1000)(2) = 2000$ personyears. The numerator • should include only new cases of the disease that occurred during the specified period. • should not include cases that occurred or were diagnosed earlier. The denominator is the population at risk. • This means that the people included in the denominator should be able to develop the disease in question during the time period covered. In practice, we usually use census data for the denominator. • The denominator should also represent the population from which the cases in the	

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				numerator arose. The population may be defined by geographic area (e.g., St. Francois County) or by membership in a specific group (e.g., employee of Company X, student at School Y). If we are studying a specific group such as students in a school or residents in a long term care facility, we should use a census of that population for an exact denominator.	
Complication incidence rates of Renal Disease, Retinopathy, Stroke and Amputation	Utilize incidence rates methods described above, for selected populations	Wisconsin: WHIO, WHA (others?)			
Prevention risk measured by incidence rates of obesity, tobacco use, stress alcohol use and physical activity rates	Utilize incidence rates methods described above, for selected populations	Wisconsin: WHIO, WHA (others?)			

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Optimal Testing (Chronic Care) Two A1C tests, And One kidney function test and/or diagnosis and treatment of kidney disease	Two A1C tests, And One kidney function test and/or diagnosis and treatment of kidney disease All of the above are during the time period specified by the measure	Claims data			These data would need to be systematically collected and reported and compared against an identified reference point
Diabetes with depression: *All or None Outcome Measure: Optimal Control (Chronic Care)*	Most recent A1C is less than 8.0% , And Most recent BP is less than 140/90 mm Hg And Most recent tobacco status is Tobacco Free	Claims data			These data would need to be systematically collected and reported and compared against an identified reference point. If there is No Documentation of Tobacco Status the patient is not compliant for this measure. Daily Aspirin or Other Antiplatelet for Diabetes Patients with the Diagnosis of Ischemic Vascular Disease Unless Contraindicated. NOTE: If there is no diagnosis of IVD, the patient is automatically numerator compliant for this measure And Statin Use NOTE: If the patient is less than age 40 and there is no diagnosis of IVD,

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					the patient is automatically numerator compliant for this measure Patients with diabetes 18-75 years of age and alive as of the last day of the MP A minimum of two diabetes coded office visits and must be seen by a PCP / Endocrinologist for two office visits in 24 months and one office visit in 12 months. Gestational Diabetes (code 648.8) is excluded.
Diabetes with depression: *Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan*	Patient's screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented	Claims data			These data would need to be systematically collected and reported and compared against an identified reference point. Referral networks for screening tools would need to be systematically established.
Diabetes with depression: *Depression Remission at Twelve Months*	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a	Claims data			These data would need to be systematically collected and reported and compared against an identified reference point. Referral networks for

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	twelve month (+/- 30 days) PHQ-9 score of less than five.				screening tools would need to be systematically established.
Optimize Care Delivery as measured by XX improvement in:					
Measure	Measure Description	Measure Sources	Measure Reporting	Measuring	Considerations/ Limitations
Optimal testing					
Optimal control	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg); The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading is <140/90 mm Hg during the measurement year.	Administrative claims, Electronic Clinical Data: Laboratory, Paper Medical Records			Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by the end of the measurement year. Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year.

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					Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by the end of the measurement year.
Screening for Depression and follow-up plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen				Exclusions: "Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist: • Patient refuses to participate • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status • Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases • Patient was referred

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					with a diagnosis of depression • Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period • Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools"
Progress towards remission for patients with Diabetes who have depression	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing				

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	depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator. Depression remission at six months; to assess the percent of adult patients who have major depression or dysthymia who have reached remission at six months (+/- 30 days) after being identified as having an initial PHQ-9 score greater than 9; Remission is identified as a PHQ-9 score less than 5.				

Process Measures to align with Best and Better Practice					
Reduce disparities[2] linked to poor health and health care as demonstrated by closing the disparity gap in all transformation goal measures by: age, payer, race, income level, educational level, gender and sexual orientation.					
Measure	**Measure Description**	**Measure Sources**	**Measure Reporting**	**Measuring**	**Considerations/ Limitations**
Age	Years a person has existed.	Claims data; Behavioral Risk Factor Surveillance System respondents were asked: "What is your age?" Respondents reported their age in years. Responses were grouped into three categories: 18-44, 45-64, and 65+.			Age adjusted vs. age specific. These data would need to be systematically collected and reported and compared against an identified reference point[3]
Payer	Medicare, Medicaid, Commercial, Uninsured (others?)	WHA, WHIO, claims data			These data would need to be systematically collected and reported and compared against an identified reference point
Race	Self-reported; Non-Hispanic white, non-Hispanic black, American Indian/Alaska Native, Asian/Pacific Islander, Hispanic, and multiple races	Claims data, BRFSS			These data would need to be systematically collected and reported and compared against an identified reference point
Income level	Self-reported	Behavioral Risk Factor Surveillance			These data would need to be systematically

[2] CDC, Disparity—The quantity that separates a group from a specified reference point on a particular measure of health that is expressed in terms of a rate, percentage, mean, or some other quantitative measure.
[3] CDC, Reference point—The specific value of a rate, percentage, proportion, mean, or other quantitative measure from which a disparity is measured.

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Measure	**Measure Description**	**Measure Sources**	**Measure Reporting**	**Measuring**	**Considerations/ Limitations**
		System respondents were asked about their annual household income: "Is your annual household income from all sources—" Responses were grouped into five categories: <$15,000, $15,000 to <$25,000, $25,000 to <$35,000, $35,000 to <$50,000, and $50,000+.			collected and reported and compared against an identified reference point
Education level	Self-reported; less than high school, high school diploma or equal, bachelor's degree, master's degree, doctorate degree or higher				These data would need to be systematically collected and reported and compared against an identified reference point
Gender	Self-reported; Male, female, transgender[4]				These data would need to be systematically collected and reported and compared against an identified reference point
Sexual orientation	Self-reported; straight, gay or lesbian, bisexual[5]	Claims data, CDC, other?			These data would need to be systematically

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[4] CDC

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					collected and reported and compared against an identified reference point

Process Measures to align with Best and Better Practice					
Improve people's active participation in health and health care as demonstrated by XX improvement in the patient activation measure (PAM)..					
Measure	Measure Description	Measure Sources	Measure Reporting	Measuring	Considerations/ Limitations
Patient Activation Measure (PAM)	A commercial product which assesses an individual's knowledge, skill, and confidence for managing one's health and healthcare.	Patient surveys, at interaction with health system.	The PAM survey measures patients on a 0-100 scale and can segment patients into one of four activation levels along an empirically derived continuum. Each activation level reveals insight into an array of health-related characteristics, including attitudes, motivators, behaviors, and outcomes.		Self-reported data. Proprietary tool. These data would need to be systematically collected and reported

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[5] CDC, Sexual Orientation and Health Among US Adults, http://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf

Process Measures to align with Best and Better Practice					
Connect people to community and social resources					
Measure	**Measure Description**	**Measure Sources**	**Measure Reporting**	**Measuring**	**Considerations/ Limitations**
How many counties have a current inventory of social health resources?	TBD	TBD	TBD	TBD	This measure does not currently exist and these data would need to be systematically collected and reported
How many counties have a current inventory that is publicly accessible?	TBD	TBD	TBD	TBD	This measure does not currently exist and these data would need to be systematically collected and reported
How many practices have actively used the inventory in the last 12 months?	TBD	TBD	TBD	TBD	This measure does not currently exist and these data would need to be systematically collected and reported
How many counties have resources that match their targeted disease needs?	TBD	TBD	TBD	TBD	This measure does not currently exist and these data would need to be systematically collected and reported
What is the volume of use (utilization) for the targeted resources listed in the inventory?	TBD	TBD	TBD	TBD	This measure does not currently exist and these data would need to be systematically collected and reported

Shared Transformation Measures by Goal					
Goal: Smarter Spending as measured by XX decrease in:					
Measure	Measure Description	Measure Sources	Measure Reporting	Measuring	Considerations/ Limitations
Total Cost of Care (TCOC) and Total Resource Use (TRU)		WHIO			WHIO only includes data from certain payers, and does not currently include allowed amounts.
Ambulatory Sensitive Conditions	Ambulatory Care Sensitive Conditions. Ambulatory Care Sensitive Conditions (ACSC's) are medical problems that are potentially preventable. For example, hypertension (high blood pressure) is a condition that can be treated outside of a hospital.[6]	WHIO			

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[6] ACSC's include Bacterial pneumonia; Congestive heart failure; Diabetes; Diabetes-acute metabolic complications; Diabetes-other; Asthma; Dehydration; Pyelonephritis/Urinary infection; Perforated or bleeding ulcer; Angina; Cellulitis; Chronic obstructive pulmonary disease; Appendicitis with rupture; Convulsions; Gastroenteritis; Epilepsy; Hypertension; Severe E.N.T. infections; Invasive cervical cancer.